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AN ADDITIONAL CASE OF PRECOCIOUS TABES.

By Julius Grinker, M. D.,
of chicago,

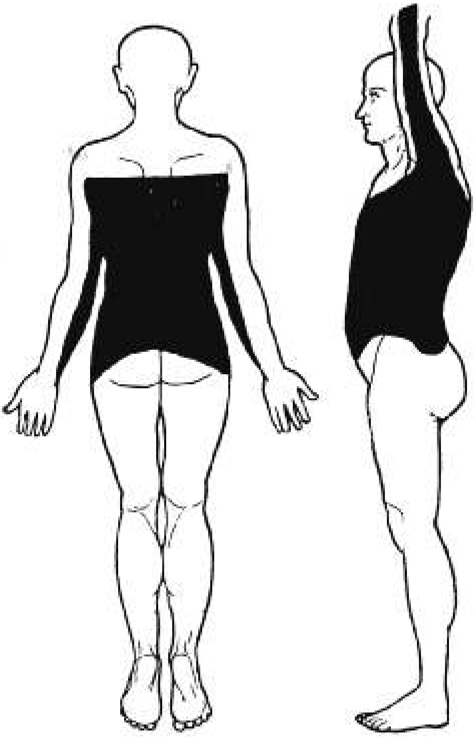
The following case, from the practice of Dr. Hugh T. Patrick, may be of some interest in connection with the preceding report. The case itself is rather unusual, as one of early tabes without evidence of syphilitic infection, with an exceptionally long course and with fragilitas ossium.

N. J. C., fifty years old, was seen September 3, 1900; family history negative. He is the oldest child, the next being seven years younger, and healthy. The patient has been married twenty-nine years, and has two healthy children of twenty and twenty-seven years respectively. Two children died—one at six weeks, of croup, the other quite young, of an accident.

The personal history is negative up to the beginning of his present trouble. When twenty-two years of age he began to suffer from sharp, shooting pains. They were severe and shifting, most severe in legs and arms, slighter and less frequent in the trunk and never invaded the head. At first these attacks occurred about once a month and lasted from a few hours to a day. Each one consisted of a sense of sharp pains, in duration from an instantaneous flash to a half minute, and occurring about two to five minutes apart.

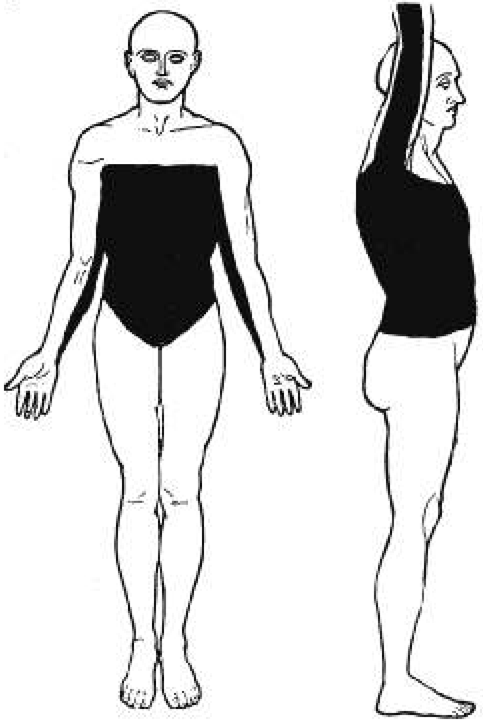
Generally they involved either arms or legs; at times both. Gradually the attacks became more frequent, until they occurred almost daily.

The pains began about the time he located in a malarial district, and were attributed to malaria. After five years' residence there, malarial fever with enlarged spleen caused him to remove to Colorado, where he remained for a year. During that time he had no pain. He then went to Western Kansas, also free from malaria, when the pains returned, and have continued ever since. In the last twelve years the longest free interval has been a month or two. The pains have been so severe and frequent that the patient complains of nothing else; but to questions replies that of late it has been difficult to start the flow of urine, sometimes very difficult; and that he has been somewhat unsteady on his feet.



Sept. 3, 1900.—Tactile anesthesia, tested by very light touch, begins at third rib; lower border rather indistinct.

In 1882 the patient sustained a fracture of the left femur, middle portion. The cause of this fracture appears to have been quite insufficient to produce such a result in a healthy individual. In lifting a weight not to exceed seventy-five pounds he "sort of wrenched" his leg, and the thigh snapped. Again, in 1884, while getting off a slowly moving train, and as his right foot struck the ground, the right thigh fractured. Two other men, one 225 pounds in weight, got off the train at the same time, without the least difficulty.



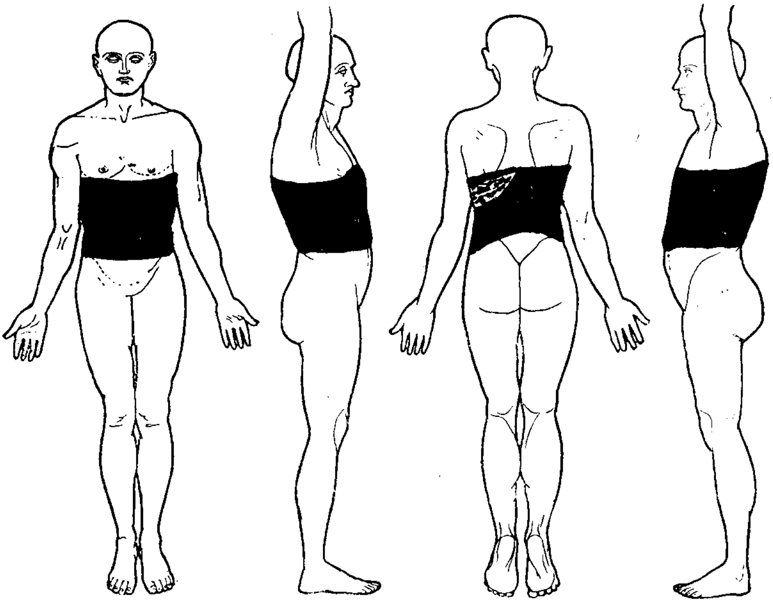
Sept. 3, 1900.—Tactile anesthesia, tested by very light touch, begins at third rib; lower border rather indistinct.

Status Præsens.—The patient is well nourished and presents no symptoms of visceral disease, nor evidence of paralysis or paresis. He has a slight convergent squint. Vision for distance was never very good. There are the typical Argyll-Robertson pupils and the Romberg sign. Incoordination is well marked in the lower extremities, slight in the upper extremities. There is distinct ulnar analgesia (Biernacki's sign), some analgesia and anesthesia of the legs, and decided trunk anesthesia. (See diagrams.)

In the month of August of this year the patient came under the observation of Dr. H. G. Brainerd, of Los Angeles, Cal., to whom I am indebted for the following report:

The patient is well nourished, although rather pale. He comes complaining of pains which are lightning in character and which occur at intervals of a few minutes to several hours apart. The seat of pain may be anywhere in the body: face, arms, trunk, legs; but of late the pains have been more persistent in the upper extremities and especially in the right forearm.

An examination shows normal sensation in left foot, while in the right foot the sense of position and pain sense are greatly impaired. Pressure upon the ulnar nerves does not cause pain. No areas of analgesia can be detected, and there is no delayed conduction of sensation. The following chart indicates the amount of trunk anesthesia as obtained by light touch with wisp of cotton.



August, 1904.—Tactile anesthesia; lighter strip in back indicates almost normal condition.

(It will be observed that there is some contraction as compared with chart of 1900.)

Bladder and rectal disturbances are absent, but occasionally there is a girdle-sensation at the lower border of the thorax. The deep reflexes are absent, while the superficial reflexes are active. There is some ataxia of station and gait when the patient closes his eyes.